Parker Healthcare Management Organization, Inc.

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DATE OF REVIEW: JANUARY 9, 2017

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed Physical Therapy (97110, 97010, G0283, 97035, 97530, 97150, 97140, 97112, 97002 and 97116) for 3 X week X 4 weeks

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Orthopedic Surgery and is engaged in the full time practice of medicine.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

XX Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a XX who was injured on XXXX, in a fall. The claimant was diagnosed with right knee pain status post arthroscopy. Treatment included twelve physical therapy sessions. A right knee arthroscopy was performed on XXXX. There were prior injections, physical therapy, medication, and routine office evaluations. The claimant remained symptomatic despite prior treatment. An evaluation on XXXX, documented bilateral knee pain and internal derangement with a right lateral meniscal tear. There was right moderate to advanced chondromalacia, hypertrophic medial plica, osteochondral defects, and post-traumatic arthropathy and arthrosis. A steroid injection was performed in the past but this did not provide any long-term relief of symptoms. The BMI was 30. There was limited left knee range of motion with guarding in the right knee. Right knee range of motion was 50-105 degrees and passively 10-110 degrees. An antalgic gait favored both sides. Synvisc and additional physical therapy were recommended. A physical therapy evaluation on XXXX, documented no current prescription medications. Range of motion at that time was 15 to 100 degrees.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE:
A previous non-certification on XXXX, was due to lack of medical necessity to justify additional formal physical therapy. The guidelines would support twelve post-operative physical therapy sessions. There were persistent knee complaints with documentation of post-traumatic arthropathy. There was a failure of corticosteroid injection and recommendation for Synvisc injection was made. There is no documentation to support the need for continued, formal physical therapy versus a self-directed home exercise program. There was prior formal physical therapy without substantial documentation to support the request such as reinjure or changes in the physical examination findings. The request for twelve physical therapy sessions, three times a week for four weeks, is not certified.

Official Disability Guidelines -TWC ODG Treatment Integrated Treatment/Disability Duration Guidelines Knee and Leg (Acute and Chronic) Back to ODG - TWC Index (updated XXXX) ODG Physical Medicine Guidelines – Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface. Dislocation of knee; Tear of medial/lateral cartilage/meniscus of knee; Dislocation of patella: Medical treatment: 9 visits over 8 weeks Pain in joint; Effusion of joint: 9 visits over 8 weeks Arthritis (Arthropathy, unspecified): Medical treatment: 9 visits over 8 weeks.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- ☐ AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- ☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- ☐ INTERQUAL CRITERIA
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- ☐ TEXAS TACADA GUIDELINES
- ☐ TMF SCREENING CRITERIA MANUAL
- ☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- ☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)